

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 229 5-29-58 et

5756

CERTIFICATE OF DEATH

Reg. Dist. No. 05746

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>George</u> Last <u>Bagley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD. Harford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Bagley</u>		14. MOTHER'S MAIDEN NAME <u>Susan Mc Nutt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>264-25-6769</u>	
17. INFORMANT <u>Rolfe d. Creswell</u>		Address <u>Harling 15 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>593x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12</u> , 19 <u>58</u> , to <u>May 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>58</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Darlington, Md</u> DATE SIGNED <u>5/19/58</u>			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u>		M.D. <u>Darlington</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		<u>Darlington, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bailey</u>		ADDRESS <u>Darlington MD</u>	
24a. REC'D BY REGISTRAR <u>W. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	
DATE <u>MAY 22 '58</u>			

CERTIFICATE OF DEATH

FILE NO. 111

DECEASED'S NAME LAST, FIRST, MIDDLE (Print or type name in full)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If deceased was engaged in any occupation, trade, profession, or service, state it here)		CAUSE OF DEATH (State the cause of death in full, giving the immediate, intermediate, and remote causes, in order)	
PLACE OF DEATH (City, State, Country)		MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)	
DATE OF DEATH (Month, day, year)		TIME OF DEATH (Hour, minute)	
SIGNATURE OF DECEASED (If deceased was capable of signing, state the date and place of signing)		SIGNATURE OF WITNESSES (If deceased was incapable of signing, state the date and place of signing)	
SIGNATURE OF PHYSICIAN (If deceased was under medical care, state the date and place of signing)		SIGNATURE OF CORONER (If deceased was under coroner's jurisdiction, state the date and place of signing)	
SIGNATURE OF REGISTRAR (If deceased was under registrar's jurisdiction, state the date and place of signing)		SIGNATURE OF CLERK (If deceased was under clerk's jurisdiction, state the date and place of signing)	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05747**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 30 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1030 W. Barry Street	
3. NAME OF DECEASED (Type or print) First SALVATORE Middle M. Last BISESI		4. DATE OF DEATH Month May Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1930
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min. 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Highway Dept City of Balto.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mariano J. Bisesi		14. MOTHER'S MAIDEN NAME Margaret Pearce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mariano J. Bisesi		Address 1030 W. Barre St., Zone 30	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from car into water	
20c. TIME OF INJURY Month, Day, Year 6:50 5/19/58 Hour 6:50 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) Edgewood (County) Harford (State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 5/20/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-23-58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) Baltimore (State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 23 '58	24b. REGISTRAR'S SIGNATURE Alf. Leach

STATE OF NEW YORK

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH
NORTH AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		MALE		30		JAN 10 1900	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
100 E. 10th St. New York		Clerk		Heart Disease		Natural	
Physician		Hospital		Burial		Cremation	
Dr. J. H. Smith		St. Mary's		Yes		No	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Date of Examination		Date of Death		Date of Burial		Date of Cremation	
Jan 10 1900		Jan 10 1900		Jan 10 1900		Jan 10 1900	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05748

Reg. Dist. No.

5757

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bel Air RD</i>		LENGTH OF STAY (in this place) <i>78 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bel Air</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>Rural</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Rhoda Belle Boone</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>May 10 1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>May 18, 1880</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Emmorton - md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>James H. Archer</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Magness</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-22-2468</i>		17. INFORMANT & ADDRESS <i>Mrs. Addie White</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
490X IMMEDIATE CAUSE (A) <i>Lobar pneumonia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerosis & disease</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-5</i> , 19 <i>58</i> , to <i>5-10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-10</i> , 19 <i>58</i> , and that death occurred at <i>10P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Dwight C Palmer</i>		M.D. <i>Bel Air md</i>		ADDRESS (Street, city, town, state) <i>5-12-52nd</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 13 1958</i>		NAME OF CEMETERY OR CREMATORY <i>Little Falls Friends</i>		LOCATION (City, town, or county) (State) <i>Fallston md</i>	
24. REC'D BY REGISTRAR DATE <i>MAY 15 '58</i>		REGISTRAR'S SIGNATURE <i>W. H. Archer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer - Benson md</i>		ADDRESS	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5758

CERTIFICATE OF DEATH

Reg. Dist. No. 05749

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>9 hrs 37 MIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Infant</u> First Middle Last <u>BRACKINS</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1958</u>
9. AGE (In years last birthday) <u>9</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>9</u> <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GERALD Wayne BRACKINS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Speer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gerald Brackin Edgewood, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (24 wks gestation)</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/4, 1958</u> to <u>5/4, 1958</u> that I last saw the deceased alive on <u>5/4, 1958</u> , and that death occurred at <u>10:00</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel-air Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Partington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>15. SIGNATURE OF CORONER [REDACTED]</p>		<p>16. SIGNATURE OF JURY [REDACTED]</p>	
<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>	
<p>21. SIGNATURE OF JURY [REDACTED]</p>		<p>22. SIGNATURE OF JURY [REDACTED]</p>	
<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>	
<p>27. SIGNATURE OF JURY [REDACTED]</p>		<p>28. SIGNATURE OF JURY [REDACTED]</p>	
<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>	
<p>33. SIGNATURE OF JURY [REDACTED]</p>		<p>34. SIGNATURE OF JURY [REDACTED]</p>	
<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>	
<p>39. SIGNATURE OF JURY [REDACTED]</p>		<p>40. SIGNATURE OF JURY [REDACTED]</p>	
<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>	
<p>45. SIGNATURE OF JURY [REDACTED]</p>		<p>46. SIGNATURE OF JURY [REDACTED]</p>	
<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>	
<p>51. SIGNATURE OF JURY [REDACTED]</p>		<p>52. SIGNATURE OF JURY [REDACTED]</p>	
<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>	
<p>57. SIGNATURE OF JURY [REDACTED]</p>		<p>58. SIGNATURE OF JURY [REDACTED]</p>	
<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>	
<p>63. SIGNATURE OF JURY [REDACTED]</p>		<p>64. SIGNATURE OF JURY [REDACTED]</p>	
<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>	
<p>69. SIGNATURE OF JURY [REDACTED]</p>		<p>70. SIGNATURE OF JURY [REDACTED]</p>	
<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>	
<p>75. SIGNATURE OF JURY [REDACTED]</p>		<p>76. SIGNATURE OF JURY [REDACTED]</p>	
<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>	
<p>81. SIGNATURE OF JURY [REDACTED]</p>		<p>82. SIGNATURE OF JURY [REDACTED]</p>	
<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>	
<p>87. SIGNATURE OF JURY [REDACTED]</p>		<p>88. SIGNATURE OF JURY [REDACTED]</p>	
<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>	
<p>93. SIGNATURE OF JURY [REDACTED]</p>		<p>94. SIGNATURE OF JURY [REDACTED]</p>	
<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>	
<p>99. SIGNATURE OF JURY [REDACTED]</p>		<p>100. SIGNATURE OF JURY [REDACTED]</p>	

WITNESSES

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be signed by the physician or coroner and the jury, if one is present. It is to be filed with the records of the Department of Health.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05750

5759

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Harre de Grace</i>		LENGTH OF STAY (in this place) <i>7 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>569 Lewis Street</i>				STREET ADDRESS (If rural give location) <i>569 Lewis Street</i>			
3. NAME OF DECEASED (Type or Print) <i>Mattie Mae Calloway</i>				4. DATE OF DEATH (Month) <i>5</i> (Day) <i>7</i> (Year) <i>19 58</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>April 22, 1889</i>	
9. AGE last birthday <i>69</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Atlantic, Ga.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Mose Head</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Tyler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs Russell Stunsbury 569 Lewis St Harre de Grace</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
420.0 IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>							<i>Hours</i>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Arteriosclerotic Heart disease</i>							<i>?</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <i>Pulmonary Emphysema</i>							<i>?</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/28</i>, 19 <i>58</i>, to <i>5/7</i>, 19 <i>58</i>, that I last saw the deceased alive on <i>5/7</i>, 19 <i>58</i>, and that death occurred at <i>1:25 P.</i>M, from the causes and on the date stated above.							
SIGNATURE <i>George J. Stunsbury</i>				ADDRESS (Street, city, town, state) <i>M.D. 569 Revolution St. Harre de Grace, Md.</i>			
DATE SIGNED <i>5/7/58</i>				DATE SIGNED <i>5/7/58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>5/8/58</i>		NAME OF CEMETERY OR CREMATORY <i>Greenwood Memorial</i>		LOCATION (City, town, or county) (State) <i>Beckley, West Virginia</i>	
24. REC'D BY REGISTRAR <i>MAY 9 '58</i>		REGISTRAR'S SIGNATURE <i>W. H. Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>		ADDRESS <i>Harre de Grace, Md.</i>	

CERTIFICATE OF DEATH

Rev. Phil. M.

1. NAME OF DECEASED

MARYLAND

Rev. Phil. M.

Rev. Phil. M.

Rev. Phil. M.

Rev. Phil. M.

Rev. Phil. M.

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Rev. Phil. M.

Rev. Phil. M.

ENCLOSURE

THE COMMISSIONER OF HEALTH

Enclosed for the Commissioner of Health are the following documents: a copy of the death certificate, a copy of the burial certificate, and a copy of the certificate of the funeral home. The documents are to be filed in the office of the Commissioner of Health.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05751

5760

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elsie Last Caudill				4. DATE OF DEATH Month May Day 31 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 31 Days 31 Hours 1958 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Richardson				14. MOTHER'S MAIDEN NAME Ellen S. Wagoner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-20-7871		17. INFORMANT Charles G. Caudill, Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma 162.1 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div> <p>(b) DUE TO</p> <p>(c) Primary source lung.</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH ?</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/20 , 19 47 , to May 31 , 19 51 , that I last saw the deceased alive on May 31 , 19 58 , and that death occurred on 3:32 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson M.D.				ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED May 31, 1958			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Fountain Green, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Lister				24a. REC'D BY REGISTRAR WIN 4 '58		24b. REGISTRAR'S SIGNATURE Willard P. Hudson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5761

CERTIFICATE OF DEATH

Reg. Dist. No. 05752

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 850 LOCUST Rd. 1			
3. NAME OF DECEASED (Type or print) BENJAMIN First CHEISTY Middle CHEISTY Last				4. DATE OF DEATH MAY 20 1958 Month MAY Day 20 Year 1958			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1897 01 yrs. Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME BEN CHEISTY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME HATTIE KANE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hosp Rndrs, Harvrd Univ. Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid Colon & Perforation & Abscess 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma, Lungs							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from MAY 20 , 19 58 , to MAY 20 , 19 58 , that I last saw the deceased alive on MAY 20 , 19 58 , and that death occurred at 12:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank D. Hacker				ADDRESS (Street, city or town, state) 608 Union Ave, Harvrd Univ. Md. DATE SIGNED 5-21-58			
PHYSICIAN'S NAME (Type) _____				22a. BURIAL, CREMATION, REMOVAL (Specify) 5/22/58			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY St. James			
22d. LOCATION (City, town, or county) Harvrd Univ. Md. (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE Harvrd Univ. Md. ADDRESS _____			
24a. REC'D BY REGISTRAR MAY 27 '58				24b. REGISTRAR'S SIGNATURE W. J. ...			

CERTIFICATE OF DEATH

1001

DATE OF DEATH		PLACE OF DEATH	
10 1978		HOME	
TIME OF DEATH		CAUSE OF DEATH	
10:00 PM		HEART DISEASE	
MANNER OF DEATH		OCCASION OF DEATH	
NATURAL		ORDINARY	
DISEASE		INJURY	
CORONARY ARTERY DISEASE		FALL	
MURDER		SUICIDE	
OTHER		OTHER	
DECEASED'S NAME		DECEASED'S AGE	
JOHN DOE		65	
DECEASED'S SEX		DECEASED'S RACE	
MALE		WHITE	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE	
10/10/1913		BALTIMORE, MD	
DECEASED'S OCCUPATION		DECEASED'S EDUCATION	
RETIRED		HIGH SCHOOL	
DECEASED'S MARITAL STATUS		DECEASED'S RELIGION	
MARRIED		CATHOLIC	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
[Signature]		1234 MAIN ST, BALTIMORE, MD	
DECEASED'S SOCIAL SECURITY NUMBER		DECEASED'S MOTHER'S MARRIAGE DATE	
[Number]		[Date]	
DECEASED'S BIRTH CERTIFICATE NUMBER		DECEASED'S DEATH CERTIFICATE NUMBER	
[Number]		[Number]	

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1001

1001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5762

CERTIFICATE OF DEATH

05753

Reg. Dist. No.

<p>1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Maryland</i> <i>MARYLAND</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamden Chase, Md.</i> c. LENGTH OF STAY IN 1b <i>35 yrs.</i></p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamden Chase, Md.</i> d. STREET ADDRESS <i>251 Allamie</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>3. NAME OF DECEASED (Type or print) <i>Horner V. Daugherty</i> First <i>V.</i> Middle <i>Daugherty</i> Last</p>				<p>4. DATE OF DEATH <i>5/18/58</i> Month <i>5</i> Day <i>18</i> Year <i>1958</i></p>							
<p>5. SEX <i>Male</i></p>		<p>6. COLOR OR RACE <i>White</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>March 16-1903</i></p>		<p>9. AGE (In years last birthday) <i>55</i> yrs.</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>19</i> Days <i>19</i> Hours <i>19</i> Min. <i>19</i></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chumbe</i></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i></p>				<p>11. BIRTHPLACE (State or foreign country) <i>Dublin Md.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Wm. S. Daugherty</i></p>				<p>14. MOTHER'S MAIDEN NAME <i>Bessie Deckman</i></p>							
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> (If yes, give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <i>Unknown</i></p>				<p>17. INFORMANT <i>Maudie H. Daugherty</i> Address <i>251 Allamie Hamden Chase Md.</i></p>			
<p>18. CAUSE OF DEATH [Enter only one cause, outline for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lungs and Brain</i> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>											
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>											
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i></p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that I attended the deceased from <i>Jan 1</i>, 19<i>58</i>, to <i>5-18</i>, 19<i>58</i>, that I last saw the deceased alive on <i>3/17</i>, 19<i>58</i>, and that death occurred at <i>M.</i>, from the cause and on the date stated above. ADDRESS (Street, city or town, state) <i>Hamden Chase Md.</i> DATE SIGNED <i>5/19/58</i></p>											
<p>ACTUAL SIGNATURE <i>E. L. Lewis</i> M.D. <i>Hamden Chase Md.</i></p>											
<p>PHYSICIAN'S NAME (Type) <i>E. L. Lewis</i></p>											
<p>22a. BURIAL CREMATION, REMOVAL (Specify) <i>5/21/58</i></p>				<p>22b. DATE THEREOF <i>5/21/58</i></p>				<p>22c. NAME OF CEMETERY OR CREMATORY <i>Southern</i></p>			
<p>22d. LOCATION (City, town, or county) (State) <i>Dublin Md.</i></p>											
<p>23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry H. Smith</i> ADDRESS <i>Hamden Chase Md.</i></p>				<p>24a. REC'D BY REGISTRAR DATE <i>MAY 27 58</i></p>				<p>24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5790

CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH o. COUNTY <u>HOTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hotford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hotford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE FORD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>DAUGHTON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-1892</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shrapping</u>	
11. BIRTHPLACE (State or foreign country) <u>Hotford MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Blomson</u>		14. MOTHER'S MAIDEN NAME <u>Maynet Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Bessie J. Daughton White MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute decompensation</u> <u>422.1</u> DUE TO <u>Chronic Aortic C-V Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16, 1958</u> to <u>May 17, 1958</u> , that I last saw the deceased alive on <u>May 16, 1958</u> , and that death occurred at <u>2 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joshua A. Hunt</u> M.D.		ADDRESS (Street, city or town, state) <u>Delta, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>Joshua A. Hunt, MD.</u>		DATE SIGNED <u>5/17/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>5-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Hunt</u>		ADDRESS <u>Delta, Pa.</u>	
24a. REC'D BY REGISTRAR <u>W. J. Hunt</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Hunt</u>	
DATE <u>MAY 20 '58</u>			

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		MARITAL STATUS [Single/Married/Widowed/Divorced]		DATE OF DEATH [Date]	
CAUSE OF DEATH [Cause]		MANNER OF DEATH [Natural/Unnatural]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		SIGNATURE OF WITNESS [Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

05755

Reg. Dist. No.

5763

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>1 1/2 years</u>		TOWN <u>BEL AIR</u>		TOWN <u>BEL AIR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 CHATHAM Rd.</u>				STREET ADDRESS (If rural give location) <u>103 CHATHAM Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FLORENCE</u> <u>REBECCA</u> <u>DOWNS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> <u>8</u> <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>AUG. 1, 1890</u>	9. AGE (last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN JAMES CLARK</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE J. BIDDLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (son) <u>L. C. DOWNS, 103 Chatham Rd., Bel Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170X IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS (BONE, CENTRAL NERVOUS SYS.)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 to 10 Months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF BREAST</u>				<u>4 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Sept. 13, 1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>METASTATIC Tumor in CERVICAL SPINE AND SPINAL CORD</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 30, 1957</u> to <u>MAY 8, 1958</u> , that I last saw the deceased alive on <u>MAY 7, 1958</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul J. Stenhouse Jr.</u>				ADDRESS (Street, city, town, state) <u>115 FULFORD Ave., BEL AIR, Md.</u> DATE SIGNED <u>5/8/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/10/58</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>		REGISTRAR'S SIGNATURE <u>W. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekens & Sons - Balt.</u> ADDRESS <u>17th</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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24 hours after death.

72 hours after death.

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CERTIFICATE OF DEATH

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1. Name of deceased (Print or write)

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1. Name of deceased (Print or write)
2. Date of death
3. Place of death
4. Cause of death
5. Signature of physician
6. Signature of registrar
7. Signature of witness
8. Signature of informant
9. Signature of funeral director
10. Signature of undertaker
11. Signature of cemetery
12. Signature of burial place
13. Signature of interment
14. Signature of burial place
15. Signature of interment
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99. Signature of interment
100. Signature of burial place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5791

CERTIFICATE OF DEATH

Reg. Dist. No. 05756

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Forest Hill		c. LENGTH OF STAY IN 1b 40 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Forest Hill		d. STREET ADDRESS Forest Hill to Hickory Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Hill to Hickory Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Lester Last Edwards		4. DATE OF DEATH Month May Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Edwards		14. MOTHER'S MAIDEN NAME Martha Crouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-36-0265	
17. INFORMANT Mrs. Pearl C. Edwards, Forest Hill, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis terminating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Congestive Heart Failure DUE TO (c) Chronic Arterio-sclerotic Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH Sudden 6-7 Months 20 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1938 , to May 5 , 19 58 , that I last saw the deceased alive on May 4 , 19 58 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED May 5, 1958			
ACTUAL SIGNATURE Willard P. Hudson M.D.			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Foster		ADDRESS Broadway + Williams St. BEL AIR, Maryland	
24a. REC'D BY REGISTRAR MAY 8 '58		24b. REGISTRAR'S SIGNATURE W. Hudson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5764

CERTIFICATE OF DEATH

Reg. Dist. No. 05757

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BELAIR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u>				d. STREET ADDRESS <u>RD # 3 Box 300</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Joseph</u> First <u>Eller-Jr</u> Middle <u>Eller-Jr</u> Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-58</u>		9. AGE (In years lost birthday) yrs. <u>3</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joseph Eller</u>				14. MOTHER'S MAIDEN NAME <u>MARY DOT BAUGESS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>John J. Eller Bel Air Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA AND SEPTICEMIA</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INTRA-UTERINE INFECTION</u> DUE TO (c) <u>PROLONGED RUPTURE OF MEMBRANES</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-10</u> , 19 <u>58</u> , to <u>5-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-13-58</u> , 19 <u>58</u> , and that death occurred at <u>6:10</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>BB Permen MAR</u>				ADDRESS (Street, city or town, state) <u>HAURE DE GRACE MD</u> DATE SIGNED <u>MAY 13-58</u>			
PHYSICIAN'S NAME (Type) <u>Walter Kirk Juretschke MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welcome Home</u>		22d. LOCATION (City, town, or county) <u>Harford</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Kirk Juretschke MD</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAY 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Juretschke</u>	

2071255XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05758

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford County Almshouse</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last	4. DATE OF DEATH <u>May</u> Month Day Year <u>23</u> 19 <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tinsmith Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Eustace</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Masterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>218-12-8303</u>	
17. INFORMANT <u>Mrs. Wm. Duggan Sr.</u>		Address <u>17 Post Rd. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Lanning</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Ant. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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FOEB-SL-BYS

U. S. Department of Agriculture

Abraham

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792

CERTIFICATE OF DEATH

Reg. Dist. No.

05759

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace (Rural) c. LENGTH OF STAY IN 1b X Havre de Grace (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Havre de Grace (Rural) d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First Middle Last Mary B. Garber			4. DATE OF DEATH Month Day Year May 5 19 58				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11 March 1899		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME William Belsterling			14. MOTHER'S MAIDEN NAME Laura R. Lauckhardt				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Rt. #2 Russell A. Garber, Havre de Grace, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO 445x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO 10 years (c) Arteriosclerosis Vascular Disease 15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from June _____, 19 50 , to May _____, 19 58 , that I last saw the deceased alive on May 5 _____, 19 58 , and that death occurred at 5A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 N. Union Ave. DATE SIGNED _____ ACTUAL SIGNATURE Frank Wolbert M.D. _____ PHYSICIAN'S NAME (Type) Frank Wolbert M.D. Havre de Grace, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/58		22c. NAME OF CEMETERY OR CREMATORY Westminister			
22d. LOCATION (City, town, or county) Cynwyd, Penna.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John G. Tarring, Aberdeen, Md.					
24a. REC'D BY REGISTRAR DATE MAY 12 '58		24b. REGISTRAR'S SIGNATURE W. Leach					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: Let this certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John S. Roberts	
Age		57	
Sex		Male	
Race		White	
Date of Death		May 11, 1933	
Place of Death		Home	
Cause of Death		Heart Disease	
Disease or Injury		Coronary Artery Disease	
Occupation		Teacher	
Residence		1234 Main St., Baltimore, Md.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witness		[Signature]	
Signature of Family		[Signature]	
Signature of Minister		[Signature]	
Signature of Priest		[Signature]	
Signature of Rabbi		[Signature]	
Signature of Imam		[Signature]	
Signature of Other		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G229 5-19-58 et

5793

CERTIFICATE OF DEATH

Reg. Dist. No.

05760

1. PLACE OF DEATH o. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin Mill Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin Mill Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>H. Hanlon</i> Last <i>Hanlon</i>		4. DATE OF DEATH Month <i>May</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1879 Dec. 29, 1918</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>3</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Rulledge Hartford Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James Hanlon</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Holland</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs John Bellungalea Baldwin</i> Address <i>Baldwin Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>CORONARY INFARCTION</i> (b) <i>General Arteriosclerosis</i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>15 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Varicose Veins both legs.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>35</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 8, 1958</i> to <i>3/2, 1958</i> that I last saw the deceased alive on <i>3/2, 1958</i> and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>		ADDRESS (Street, city or town, state) <i>FORK MD.</i>	
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Johns</i>	22d. LOCATION (City, town, or county) (State) <i>Hydco, Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin E. Kory</i> ADDRESS <i>Janet Howell Rd</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 5 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5766

CERTIFICATE OF DEATH

Reg. Dist. No.

05761

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Hanover Street		d. STREET ADDRESS 22 Hanover Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Mae Last Hardy		4. DATE OF DEATH Month May Day 9 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 May 1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietitian		10b. KIND OF BUSINESS OR INDUSTRY Hospital (VA)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Edward L. Branch		14. MOTHER'S MAIDEN NAME Mary J. Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-24-2881	
17. INFORMANT Helen Frisby		Address 2 Hanover St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of the ovary DUE TO (c) Metastatic Carcinoma of the ovary		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/6 , 19 58 , to 5/9 , 19 58 , that I last saw the deceased alive on 5/9 , 19 58 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Stansbury M.D.		ADDRESS (Street, city or town, state) 569 Revolution St. DATE SIGNED	
PHYSICIAN'S NAME (Type) George T. Stansbury M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/13/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) (State) RD. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John F. Harriag Aberdeen Md.		24a. REC'D BY REGISTRAR MAY 16 '58 24b. REGISTRAR'S SIGNATURE W. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Barber

Barber

Barber

Barber

25 Hanover Street

25 Hanover Street

Anna

Anna

Female Colored

Female Colored

Hospital (VA)

Hospital (VA)

USA

Edward J. Brown

Edward J. Brown

322-3081

322-3081

322-3081

509 Revolution St.

George E. Brown, Jr.

George E. Brown, Jr.

2/1/58

2/1/58

2/1/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05762**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford 5762 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harmede Brook Id. c. LENGTH OF STAY IN 1b 1d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Robin Hood Road			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harmede Brook 24 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Beth 2 Hartman First Middle Last			4. DATE OF DEATH May 18 19 58 Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1958		9. AGE (In years last birthday) 13 yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Rowan Creek Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Cisco Carr		
14. MOTHER'S MAIDEN NAME Anna May Taylor			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. none			17. INFORMANT Robin Hood Road Anna May Taylor Rowan Creek, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity (at 7 mo) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-18-58	
EXAMINER'S NAME (Type) Gerald C Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> B. A. in, md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 5/18/58		22c. NAME OF CEMETERY OR CREMATORY Angel Hill	
22d. LOCATION (City, town, or county) (State) Harmede Brook Md.		23. FUNERAL DIRECTOR'S SIGNATURE Wm Howard Beach		24a. REC'D BY REGISTRAR May 20 '58	
24b. REGISTRAR'S SIGNATURE Wm Howard Beach					

1000297XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BASTARDY IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: WILLIAM J. BROWN
 SEX: MALE AGE: 45 DATE OF BIRTH: 1900
 PLACE OF BIRTH: NEW YORK OCCUPATION: LABORER
 MARITAL STATUS: MARRIED NAME OF SPOUSE: MARY J. BROWN
 ADDRESS: 1234 MAIN ST. BALTIMORE, MD.
 DATE OF DEATH: 1945 PLACE OF DEATH: HOSPITAL
 CAUSE OF DEATH: HEART DISEASE
 MEDICAL HISTORY: NO PREVIOUS ILLNESS
 SIGNATURE OF EXAMINER: [Signature]
 TITLE: PHYSICIAN
 BOARD OF HEALTH: APPROVED
 DATE: 1945

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.
 IT IS THE DUTY OF THE EXAMINER TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH.
 THE BOARD OF HEALTH HAS THE HONOR TO CERTIFY THAT THE DECEASED WAS A BASTARD.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05763

5768

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY 75X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Homestead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1413 Hays Street	
3. NAME OF DECEASED (Type or print) First Stephen Middle E. (or Hawrylin) Last Hawryliw		4. DATE OF DEATH Month May Day 21 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1920
9. AGE (In years last birthday) 38 yrs.		10. FUNDUS YEAR 38 Months 38 Days 38 Hours 38 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exercise Boy		10b. KIND OF BUSINESS OR INDUSTRY Race Track	
11. BIRTHPLACE (State or foreign country) McKeesport, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Hawryliw		14. MOTHER'S MAIDEN NAME Anne White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. F. Giordano		Address 5053 Ampere St. Pittsburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.1 Fatty liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic alcoholism DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		DATE SIGNED 5-21-58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 23, 1958	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery,	22d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Vernon Lemmon		ADDRESS 4611 Park Heights, Balto. Md.	
24a. REC'D BY REGISTRAR MAY 23 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

5794 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Levell</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Havre de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>Taylor</i> Last <i>Hinton</i>		4. DATE OF DEATH Month <i>5</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 30 - 1870</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	
11. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Alfred Taylor</i>		14. MOTHER'S MAIDEN NAME <i>James Richards</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>James Richards</i>		Address <i>Butte 18 Wd. 1806 Holwyn Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Large Intestine</i> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 19 <i>58</i> , to <i>May 13</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 12</i> , 19 <i>58</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dudley Phillips MD</i>		ADDRESS (Street, city or town, state) <i>Darlington, Md</i>	
PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>		DATE SIGNED <i>5/13/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>5/15/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Weston Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen P. O. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Harving</i>		ADDRESS <i>Aberdeen, Maryland</i>	
24a. REC'D BY REGISTRAR <i>W. Beach</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	
DATE <i>MAY 16 '58</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 2

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death	
6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
11. Signature of informant		12. Signature of witness		13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury		25. Signature of jury	
26. Signature of jury		27. Signature of jury		28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury		34. Signature of jury		35. Signature of jury	
36. Signature of jury		37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury		49. Signature of jury		50. Signature of jury	
51. Signature of jury		52. Signature of jury		53. Signature of jury		54. Signature of jury		55. Signature of jury	
56. Signature of jury		57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury		65. Signature of jury	
66. Signature of jury		67. Signature of jury		68. Signature of jury		69. Signature of jury		70. Signature of jury	
71. Signature of jury		72. Signature of jury		73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury		85. Signature of jury	
86. Signature of jury		87. Signature of jury		88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury		94. Signature of jury		95. Signature of jury	
96. Signature of jury		97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	



Vertical text on the right margin, likely a filing or processing stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5769

CERTIFICATE OF DEATH

Reg. Dist. No. 05765

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAARE de GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>North East</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Halbrook</u>				4. DATE OF DEATH Month Day Year <u>May 1 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1958</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>5</u> <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Holbrook, Patricia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>North East, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - A. H. L. L. S.</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 to 72</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1</u> , 19 <u>58</u> to <u>5-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-1</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5-2-58</u>			
PHYSICIAN'S NAME (Type)				M.D. <u>B. H. L. L. S.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Haare de Grace, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Kelly Administrator</u>				24a. REC'D BY REGISTRAR DATE <u>May 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2071351 XVI

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. SEX a. MALE b. FEMALE		3. AGE a. YEARS b. MONTHS c. DAYS	
4. DATE OF DEATH a. YEAR b. MONTH c. DAY		5. TIME OF DEATH a. HOUR b. MINUTE		6. PLACE OF DEATH a. HOME b. HOSPITAL c. OTHER	
7. CAUSE OF DEATH a. DISEASE b. INJURY c. OTHER		8. MANNER OF DEATH a. NATURAL b. ACCIDENT c. SUICIDE d. HOMICIDE		9. MEDICAL HISTORY a. PREVIOUS DISEASES b. SURGERIES c. DRUGS	
10. OCCUPATION a. TRADE b. PROFESSION c. OTHER		11. EDUCATION a. YEARS b. DEGREE		12. SOCIAL HISTORY a. SMOKING b. ALCOHOL c. DRUGS	
13. FAMILY HISTORY a. PARENTS b. SIBLINGS c. OTHER		14. ENVIRONMENTAL HISTORY a. HOME b. WORK c. OTHER		15. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	
16. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		17. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		18. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	
19. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		20. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		21. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	
22. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		23. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		24. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	
25. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		26. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		27. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	
28. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		29. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY		30. SIGNATURE OF DEATH CERTIFICATE a. DEATH CERTIFICATE b. MEDICAL HISTORY c. SOCIAL HISTORY	

THIS DEPARTMENT OF HEALTH HAS THE HONOR TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE FACTS AS REPORTED TO IT BY THE DEATH CERTIFICATE OFFICER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5770

CERTIFICATE OF DEATH

05766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre de Grace, Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>1712 S. Union Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Sue</i> Middle <i>K.</i> Last <i>Hollahan</i>		4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/11/1897</i>
9. AGE (In years lost birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Schools</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Kahoe</i>		14. MOTHER'S MAIDEN NAME <i>Rose Lee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Rosealie H. Woodbury</i> Address <i>Harford 712 S. Union, Harford, Harre de Grace</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Antero-septal Myocardial Infarction (coronary)</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 11</i> , 1958, to <i>May 11</i> , 1958, that I last saw the deceased alive on <i>May 11</i> , 1958, and that death occurred at <i>2:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. J. Simon</i>		ADDRESS (Street, city or town, state) <i>200 S. Union Ave, Harre de Grace</i>	
PHYSICIAN'S NAME (Type) <i>E. J. SIMON</i>		DATE SIGNED <i>MAY 15 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wm. E. Egan</i>	22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barry H. Egan</i>		24a. REC'D BY REGISTRAR <i>W. E. Egan</i>	
ADDRESS <i>Harre de Grace, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Egan</i>	
DATE <i>MAY 15 1958</i>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Handwritten: <i>John Doe</i>]		2. SEX [Handwritten: <i>Male</i>]		3. AGE [Handwritten: <i>45</i>]	
4. DATE OF BIRTH [Handwritten: <i>Jan 15 1900</i>]		5. PLACE OF BIRTH [Handwritten: <i>Baltimore, Md.</i>]		6. OCCUPATION [Handwritten: <i>Teacher</i>]	
7. MARITAL STATUS [Handwritten: <i>Married</i>]		8. DATE OF MARRIAGE [Handwritten: <i>June 10 1925</i>]		9. PLACE OF MARRIAGE [Handwritten: <i>Baltimore, Md.</i>]	
10. CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]		11. MEDICAL HISTORY [Handwritten: <i>None</i>]		12. PRESENT ILLNESS [Handwritten: <i>None</i>]	
13. DATE OF DEATH [Handwritten: <i>Dec 10 1945</i>]		14. PLACE OF DEATH [Handwritten: <i>Home</i>]		15. TIME OF DEATH [Handwritten: <i>10:00 AM</i>]	
16. SIGNATURE OF PHYSICIAN [Handwritten: <i>John Doe</i>]		17. SIGNATURE OF REGISTRAR [Handwritten: <i>John Doe</i>]		18. SIGNATURE OF WITNESS [Handwritten: <i>John Doe</i>]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE
 MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

5771

CERTIFICATE OF DEATH

Reg. Dist. No.

05767

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Gilbert</u> Last <u>James</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7th 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min. <u>58</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foot App</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George B. James</u>		14. MOTHER'S MAIDEN NAME <u>Sara Keith Ley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Jacob E. James</u>		Address <u>Aberdeen Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>~10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 1958, to <u>May 10</u> , 1958, that I last saw the deceased alive on <u>May 10</u> , 1958, and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett Jr.</u>		ADDRESS (Street, city or town, state) <u>Aberdeen Md</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		DATE SIGNED <u>5-11-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/14/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockbury</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		ADDRESS <u>Aberdeen Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>Aberdeen</u>	

VS A15C 1-55 10M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5772

CERTIFICATE OF DEATH

Reg. Dist. No. 05769

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Hartf.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre-de-Grace</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre-de-Grace</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>	
d. STREET ADDRESS <i>1819 Adams ST.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i> First <i>Jones</i> Middle <i>Jones</i> Last		4. DATE OF DEATH Month <i>5</i> Day <i>23</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i>
9. AGE (In years last birthday) <i>47</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Franklin DuFF</i>		14. MOTHER'S MAIDEN NAME <i>Annie Hanshaw</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Hosp Records, Harford County, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rectal Hemorrhage</i> <i>581.0</i> DUE TO <i>Cirrhosis of the Liver with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Portal Hypertension</i> (b) <i>Months to</i> (c) <i>years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/20</i> , 19 <i>58</i> , to <i>5/23</i> , 19 <i>58</i> , that I lost saw the deceased alive on <i>5/23</i> , 19 <i>58</i> , and that death occurred at <i>5:20 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>600 S. Union Av. Harre-de-Grace</i> DATE SIGNED <i>5/24/58</i>			
ACTUAL SIGNATURE <i>W. H. Sadowsky</i> M.D.			
PHYSICIAN'S NAME (Type) <i>W. H. SADOWSKY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5/27/58</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harre-de-Grace, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burroughs & Son, Harre-de-Grace, Md</i>		24a. REC'D BY REGISTRAR <i>May 27 1958</i>	
24b. REGISTRAR'S SIGNATURE <i>Allen</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05770

5796

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James B Lunny</u> First Middle Last		4. DATE OF DEATH <u>May 10, 1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Station</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B Lunny</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn O. Orr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-16-4830-</u>	
17. INFORMANT <u>Mrs James B. Lunny</u> Address <u>Burlington, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Inf</u> INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1954</u> , to <u>May 10, 1958</u> , that I last saw the deceased alive on <u>April 20, 1958</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u>		DATE SIGNED <u>5/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		ADDRESS (Street, city or town, state) <u>Burlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 14, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Huber Cr.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Burlington Md</u>		24a. REC'D BY REGISTRAR <u>Aw. Smith</u>	
DATE <u>MAY 14 '58</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. RACE		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	

MASSACHUSETTS
STATE DEPARTMENT OF HEALTH
BIRTH ONE 18

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05771

5797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Whitley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Ground</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corbin</u> 55x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital, AFG, Md.</u>		d. STREET ADDRESS <u>310 Ruby Street</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE</u> First Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 January 1912</u> 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Loyall, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joe Fee</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>401 34 0524</u>	
17. INFORMANT (Husband) <u>Det A, SP Trps (9301)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant melanoma with metastasis to lung, lymph nodes and bone.</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 months</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from <u>4 May</u> 19 <u>58</u> , to <u>5 May</u> 19 <u>58</u> , that I last saw the deceased alive on <u>5 May</u> 19 <u>58</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Joseph N. Silverstein</u> M.D.	DATE SIGNED <u>5 May 1958</u>
PHYSICIAN'S NAME (Type) <u>JOSEPH N. SILVERSTEIN, CAPT, MC</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Corbin, Kentucky</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Lanning</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Lanning</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5773

CERTIFICATE OF DEATH

05772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BARRY</u> Middle <u>J</u> Last <u>PLUNKETT, JR.</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1907</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUG SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PLUNKETT, EDWARD</u>		14. MOTHER'S MAIDEN NAME <u>BRIAN, ELIZABETH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>193-05-0647</u>	
17. INFORMANT <u>PLUNKETT, BARRY J. JR., MD</u>		Address <u>617 W BELAIR AVE, BALTIMORE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 1st, 1957</u> to <u>May 8th, 1958</u> , that I last saw the deceased alive on <u>May 8th, 1958</u> , and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Too, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. May 8/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u>		<u>Havre de Grace, Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>5-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST Stephen's</u>	22d. LOCATION (City, town, or county) (State) <u>Bradshaw - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd - 14 -</u>	
24a. REC'D BY REGISTRAR <u>MAY 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Seach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05773

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 40</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilson Presley</u>		4. DATE OF DEATH <u>May 25 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>No record</u>
9. AGE (in years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carving Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No record</u>		14. MOTHER'S MAIDEN NAME <u>No record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>No record</u>	
17. INFORMANT <u>Maryland State Police - Benson, Fred</u>		Address <u>usd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>812X</u> DUE TO (c) <u>812X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-24-58</u>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>	20f. (City or town) <u>Aberdeen</u> (County) <u>Hartford</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-25-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Georgia, Alabama</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harrison Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>W. J. Pearson</u> DATE <u>MAY 28 1958</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Pearson</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPT. OF HEALTH
BALTIMORE



DATE OF DEATH
PLACE OF DEATH



DEPT. OF HEALTH
BALTIMORE

[Faint, mostly illegible text and markings on the form, including checkboxes and handwritten notes.]

5775

CERTIFICATE OF DEATH

Reg. Dist. No. 05774

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>10 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>51a Harford Rd. Star Rt.</u>	
3. NAME OF DECEASED (Type or print) First <u>Judson</u> Middle <u>Joseph</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 29, 1881</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min. <u>58</u>	IF UNDER 24 HRS. <u>19</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Master Loan Co</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Joseph Price</u>		14. MOTHER'S MAIDEN NAME <u>Effie Cveronte</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-03-1888</u>	
17. INFORMANT Address <u>Mrs. Epla D. Price, Reidsville, N. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac DeCompensation</u> 422.1 DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>years.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Prostatic Hypertrophy ② Hypostatic Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 21st, 1958</u> to <u>May 22nd, 1958</u> , that I last saw the deceased alive on <u>May 22nd, 1958</u> , and that death occurred at <u>8:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Judson Price</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. 5/22/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D. Harre de Grace, Md</u>		DATE SIGNED <u>5/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>W. Ruck</u>	24b. REGISTRAR'S SIGNATURE <u>W. Ruck</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockingham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>118 Scale Street</u>	
3. NAME OF DECEASED (Type or print) <u>Hubert Ransom</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/30/1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Line man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Line Constr</u>	
11. BIRTHPLACE (State or foreign country) <u>Marlboro G. SC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Ben F. Ransom</u>		14. MOTHER'S MAIDEN NAME <u>Mary P. Mullis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mark's Friend from Rockingham, N.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>9/4.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Touched Distribution Line</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-23-58</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ford's Lane</u>	20f. (City or town) (County) (State) <u>Perryman Harford Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wright</u>	22d. LOCATION (City, town, or county) (State) <u>Harford N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Longtin R. Harde</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT STATE
HEALTH DEPT.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CHIEF OF BUREAU

Form with multiple sections for medical examination and death certification, including checkboxes and lines for text entry.

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. OCCUPATION: _____

5. PLACE OF BIRTH: _____

6. DATE OF DEATH: _____

7. TIME OF DEATH: _____

8. CAUSE OF DEATH: _____

9. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE

10. SIGNATURE OF MEDICAL EXAMINER: _____

11. SIGNATURE OF WITNESS: _____

12. SIGNATURE OF CORONER: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5777

CERTIFICATE OF DEATH

Reg. Dist. No. 05776

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 Edmund Street		d. STREET ADDRESS 126 Edmund Street	
3. NAME OF DECEASED (Type or print) First Louise Middle M. Last Ray		4. DATE OF DEATH Month May Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 18 August 1891	9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Adkinson		14. MOTHER'S MAIDEN NAME Mollie Tarbutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-32-2136-AB	
17. INFORMANT James B. Ray		Address 126 Edmund St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congested Heart Disease DUE TO Hypertension & Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro Vascular Accident (c) 3 Years			INTERVAL BETWEEN ONSET AND DEATH 3 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 1 , 1958, to MAY 8 , 1958, that I last saw the deceased alive on MAY 7 , 1958, and that death occurred at 8:00AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andre Weiss M.D.		ADDRESS (Street, city or town, state) 17 N. Phila. Blvd. DATE SIGNED 5/9/58	
PHYSICIAN'S NAME (Type) Andre Weiss M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/11/58	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) RD. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarving ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR MAY 13 '58	24b. REGISTRAR'S SIGNATURE Andre Weiss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5778

CERTIFICATE OF DEATH

05777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlet Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlet Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>816 Juniata</i>	
3. NAME OF DECEASED (Type or print) First <i>Anthony</i> Middle <i>Joseph</i> Last <i>Reginaldi</i>		4. DATE OF DEATH Month <i>07</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> UNWIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/5/1922</i>
9. AGE (In years last birthday) <i>36</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Refinery Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Anderson Printing Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Chesler Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Reginaldi</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Ann Reginaldi</i>		Address <i>816 Juniata St. Hamlet Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF THE LIVER</i> <i>156.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/25</i> , 19 <i>57</i> , to <i>5/7</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/7</i> , 19 <i>58</i> , and that death occurred at <i>1:50 P.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>HAVRE DE GRACE, MD.</i>			
ACTUAL SIGNATURE <i>Benjamin D. Hirsch</i> M.D.			
PHYSICIAN'S NAME (Type) <i>BENJAMIN D. HIRSCH</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>5/10/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Elm</i>	22d. LOCATION (City, town, or county) (State) <i>Hamlet Chase, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin D. Hirsch</i>		ADDRESS <i>Hamlet Chase, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Benjamin D. Hirsch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DECLARANT

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECLARANT</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF MINISTER</p>		<p>15. SIGNATURE OF CLERGYMAN</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF CLERK</p>		<p>20. SIGNATURE OF REGISTRAR</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.

RECEIVED BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5779

CERTIFICATE OF DEATH

Reg. Dist. No.

05778

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b X Perryman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia H. Richardson		4. DATE OF DEATH Month Day Year May 23 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 June 1875
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min. 23 19 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Emp. (Retired) U.S. Post Office		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Winfield B. Harris	
14. MOTHER'S MAIDEN NAME Laura Mitchell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Ryland Mitchell Address Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hr. 10 yr. 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus — 3 mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , 19 5-23-1958 , to 5-23-1958 , that I last saw the deceased alive on 5-23-1958 , 19 5-23-1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 5-24-58			
ACTUAL SIGNATURE Peter P. Rodman, M.D.		PHYSICIAN'S NAME (Type) Peter P. Rodman M.D. Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/58	22c. NAME OF CEMETERY OR CREMATORY Grove	22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 1958 24b. REGISTRAR'S SIGNATURE W. S. Couch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Hanford

Age 45

Sex Male

Married

Occupation

Date of Death

Hanford Memorial Hospital

Physician

Dr. J. H. Hanford

SS

20 June 1972

U.S. Post Office

Local Health Officer

U.S. Post Office

Maryland

Maryland

Wiltshire

No

Physician

Admission

77

MD-20

MD-20

as present

Peter E. Hogan

M.D.

Admission

Maryland

from

Local Health Officer

Hanford, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05779

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director's page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-inquest permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Hartford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston c. LENGTH OF STAY IN 1b 1 Month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dale Hess Farm		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Albany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Albany Geo. d. STREET ADDRESS 205 Highland Alley	
3. NAME OF DECEASED (Type or print) Turner First Turner Middle Robinson Last Robinson		4. DATE OF DEATH May 1 1958 Month May Day 1 Year 1958	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1935 9. AGE (In years last birthday) 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Horace Robinson		14. MOTHER'S MAIDEN NAME Essie May Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 258-58-9268	
17. INFORMANT Dale Hess Fallston		Address Hartford Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 912.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accident - Tractor	
20c. TIME OF INJURY Month, Day, Year May 1 1958 Hour 5-1 a. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/> Parent's Farm	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fallston Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Be/Air Md 5-1-58	
EXAMINER'S NAME (Type) Gerold C PALMER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5 1958	
22c. NAME OF CEMETERY OR CREMATORY Union Union Men's Park		22d. LOCATION (City, town, or county) (State) Albany Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Martin G Kent		24a. REG'D MED REGISTRAR'S SIGNATURE W. J. Leach	

FOR STATE
HEALTH DEPT

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1 Item 3 Film G228 5-12-58 et 5780 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05780

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>40 yrs</i>		d. STREET ADDRESS <i>701 N. Adams</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>J. Lykee</i> First <i>Scobey</i> Middle <i>(Scobey)</i> Last		4. DATE OF DEATH <i>5/5/1958</i> Month <i>5</i> Day <i>5</i> Year <i>19</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/1/1880</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Crown House Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Peny Print Mfg</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Holmes Scobey</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Van Matter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Alberta Sentman</i> Address <i>701 N. Adams, Harford, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-1</i> , 19 <i>55</i> , to <i>5-5</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 3-</i> , 19 <i>55</i> , and that death occurred at <i>5-5</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. L. Lewis</i> M.D.		ADDRESS (Street, city or town, state) <i>Harford, Md.</i> DATE SIGNED <i>5-6-58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>5/8/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Harford, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Conington Ham</i> ADDRESS <i>Harford, Md.</i>		24a. REC'D BY REGISTRAR <i>MAY 8 '58</i>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death	
6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
11. Signature of informant		12. Signature of witness		13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury		25. Signature of jury	
26. Signature of jury		27. Signature of jury		28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury		34. Signature of jury		35. Signature of jury	
36. Signature of jury		37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury		49. Signature of jury		50. Signature of jury	
51. Signature of jury		52. Signature of jury		53. Signature of jury		54. Signature of jury		55. Signature of jury	
56. Signature of jury		57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury		65. Signature of jury	
66. Signature of jury		67. Signature of jury		68. Signature of jury		69. Signature of jury		70. Signature of jury	
71. Signature of jury		72. Signature of jury		73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury		85. Signature of jury	
86. Signature of jury		87. Signature of jury		88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury		94. Signature of jury		95. Signature of jury	
96. Signature of jury		97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

RECEIVED
JAN 11 1904
DEPT. OF HEALTH

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5799 CERTIFICATE OF DEATH

Reg. Dist. No.

05781

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, Rural	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Joppa Rd. & Mountain Rd.		d. STREET ADDRESS Joppa Rd. & Mountain Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henrietta Middle Mitchell Last Smith		4. DATE OF DEATH Month May Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Rev. Thomas S.C. Smith	
14. MOTHER'S MAIDEN NAME Mary Stump		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Edwin Bond, Joppa, Harford Co., Md. R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Dis. DUE TO (c) 12 hrs. 12 yrs.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 24 , 19 47 , to 5/26 , 19 58 , that I last saw the deceased alive on 5/25 , 19 58 , and that death occurred at 12 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Clifford F. Hudson M.D. ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON, FORK MD			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 5-29-1958	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson		24. REC'D BY REGISTRAR DATE MAY 28 '58	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE W. H. Smith	

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doi:10.1017/S0022292409990730

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5781

CERTIFICATE OF DEATH

05782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE	
c. LENGTH OF STAY IN 1b 23 DAYS		d. STREET ADDRESS 167 BLOOMSBURY AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHIRLEY Middle SPRINGER Last		4. DATE OF DEATH MAY 27 1958 Month 27 Day 1958 Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY Student	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HOWARD SPRINGER		14. MOTHER'S MAIDEN NAME FLORENCE HAYES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 286.0 Cardiac Decompensation DUE TO (b) Cochlear's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Emphysema DUE TO		INTERVAL BETWEEN ONSET AND DEATH Infant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **May 4, 1958** to **MAY 27, 1958**, that I last saw the deceased alive on **May 27, 1958**, and that death occurred at **9:15 A.M.** from the causes and on the date stated above.

ACTUAL SIGNATURE **E. J. Simon** M.D. ADDRESS (Street, city or town, state) **Havre de Grace** DATE SIGNED **MARYLAND**

22a. BURIAL-CREATION, REMOVAL (Specify)	22b. DATE THEREOF 5/30/58	22c. NAME OF CEMETERY OR CREMATORY Angel Hill	22d. LOCATION (City, town, or county) (State) Havre de Grace Md
23. FUNERAL DIRECTOR'S SIGNATURE Prington Rm		24a. REC'D BY REGISTRAR June 3 '58	24b. REGISTRAR'S SIGNATURE W. Deane

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH 1958		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS Several Months		18. PRESENT ILLNESS Heart Disease		19. PREVIOUS ILLNESSES Hypertension		20. MEDICAL HISTORY None	
21. NAME OF PHYSICIAN Dr. J. H. Smith		22. NAME OF HOSPITAL None		23. NAME OF NURSE None		24. NAME OF ASSISTANT None		25. NAME OF ATTENDING None	
26. NAME OF FUNERAL HOME None		27. NAME OF BURIAL PLACE None		28. NAME OF CEMETERY None		29. NAME OF INTERMENT None		30. NAME OF CREMATION None	
31. NAME OF CORONER None		32. NAME OF JURY None		33. NAME OF JUDGE None		34. NAME OF CLERK None		35. NAME OF RECORDS None	
36. NAME OF REGISTRAR None		37. NAME OF CLERK None		38. NAME OF RECORDS None		39. NAME OF CREMATION None		40. NAME OF INTERMENT None	

103-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5800

CERTIFICATE OF DEATH

Reg. Dist. No. 05783

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Forest Hill				c. LENGTH OF STAY IN 1b Entire life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rural Forest Hill			
3. NAME OF DECEASED (Type or print) First Howard Middle Stewart Last Stewart				4. DATE OF DEATH Month May Day 18 Year 1958			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15 1889	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Harford Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward Stewart			
14. MOTHER'S MAIDEN NAME Anna Wells				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 218-32-47705				17. INFORMANT Mrs Agnes Robinson Forest Hill Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, second episode 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) Chronic hypertensive cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from Aug 12 1955 , to May 18 1958 , that I last saw the deceased alive on May 17 1958 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson				ADDRESS (Street, city or town, state) _____ DATE SIGNED 5/19/58			
PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D.				FOREST HILL, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21 1958		22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Forest Hill Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Martin Skutz				ADDRESS Janet Skutz		24a. REC'D BY REGISTRAR May 23 58	
24b. REGISTRAR'S SIGNATURE Deane							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE CITY OF BALTIMORE		PLACE OF DEATH STATE OF MARYLAND COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED JAMES H. HARRIS		NAME OF DECEASED JAMES H. HARRIS	
SEX Male		SEX Male	
AGE 45 years		AGE 45 years	
OCCUPATION Laborer		OCCUPATION Laborer	
MARITAL STATUS Single		MARITAL STATUS Single	
CAUSE OF DEATH Myocardial Infarction		CAUSE OF DEATH Myocardial Infarction	
DATE OF DEATH 10/15/1910		DATE OF DEATH 10/15/1910	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		PLACE OF DEATH Home	
SIGNATURE OF DECEASED (None)		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF JURY (None)		SIGNATURE OF JURY (None)	
SIGNATURE OF JUDGE (None)		SIGNATURE OF JUDGE (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF CLERK (None)	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5782

CERTIFICATE OF DEATH

Reg. Dist. No. 115784

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>11 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		e. STREET ADDRESS <u>07X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>LOLA</u> Middle <u>ADELINE</u> Last <u>SUMNER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PRESTON MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ELLEN THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	
17. INFORMANT <u>DAUGHTER</u> Address <u>RISING SUN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Metastatic Ca of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5</u> 19 <u>54</u> to <u>5/20</u> 19 <u>58</u> that I last saw the deceased alive on <u>5/20</u> 19 <u>58</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u>		DATE SIGNED <u>5/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Baptist Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Conowingo Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E M Miller</u>		ADDRESS <u>Rising Sun Md.</u>	
24a. REC'D BY REGISTRAR <u>Al Lewis</u>		DATE <u>MAY 22 '58</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF MENTAL PHYSICIAN		18. SIGNATURE OF CHURCH CLERGYMAN		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5783

CERTIFICATE OF DEATH

05785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. LENGTH OF STAY IN 1b <u>154rs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1958</u>		d. STREET ADDRESS <u>202 Thomas Street</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle</u> First <u>ETHEL</u> Middle <u>TOWNSLEY</u> Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles St. Harford Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James O. Townsley</u>		14. MOTHER'S MAIDEN NAME <u>Annie C. Coe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Thomas Borneman</u>		Address <u>Harford Co</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension Cardiovascularis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10-15 years</u> (c) <u>1 hour</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>6 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 May</u> , 19 <u>58</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air Md</u>	
DATE SIGNED <u>6 May 58</u>			
PHYSICIAN'S NAME (Type) <u>Charles Richardson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 9</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville, Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman E. Knudsen</u>		ADDRESS <u>Jarrettsville Md</u>	
24a. REC'D BY REGISTRAR <u>MAY 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5784

CERTIFICATE OF DEATH

05786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>118 Maulsby Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>F</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 7, 1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stove Shop Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stove Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Mary (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Charles J. Kaufman</u> Address <u>1417 Olive St., Balto. 30, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Embolus.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>11 May</u> , 1958, that I last saw the deceased alive on <u>10 May</u> , 1958, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Thos. A. E. Moseley, Jr.</u> M.D. _____							
PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR.</u> <u>Warrentsville</u> <u>Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Anne Arundel Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>Broadway + Williams St</u> <u>BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1914	
NAME OF DECEASED [illegible]		SEX [illegible]	
AGE [illegible]		RACE [illegible]	
PLACE OF BIRTH [illegible]		PLACE OF DEATH [illegible]	
OCCUPATION [illegible]		CAUSE OF DEATH [illegible]	
DATE OF DEATH [illegible]		TIME OF DEATH [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]	
CERTIFICATE NO. [illegible]		COUNTY [illegible]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1906, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, 1914.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5785 CERTIFICATE OF DEATH

Reg. Dist. No. 05787

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Hart-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>310 N. Stokes.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Boy</u> Middle <u>Walls</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/58</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Anylee Lloyd Walls</u>		14. MOTHER'S MAIDEN NAME <u>Marian Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>310 Stokes.</u>	
17. INFORMANT <u>Anylee Lloyd Walls, Hartford-de-Grace Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staph Pneumonia</u> <u>763.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Septicemia</u> cause (c) <u>Pneumonia 3-6-58</u> lying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>24 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>58</u> , to <u>5/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>58</u> , and that death occurred at <u>8:20 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>B. H. Jones, Jr.</u>		ADDRESS (Street, city or town, state) <u>310 Stokes.</u> DATE SIGNED <u>5-18-58</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22a. REC'D BY REGISTRAR DATE <u>MAY 20 '58</u>	
22b. DATE THEREOF <u>5/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Chapel</u>	
22d. LOCATION (City, town, or county) (State) <u>Bellin Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hartford-de-Grace, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '58</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1875		BALTIMORE		MD		USA		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
JAN 15 1920		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		NONE		NONE		NONE	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE		FECES		SWEAT		TEETH	
10:30 AM		98.6		60		16		120/80		NORMAL		NORMAL		NORMAL		NORMAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF CHURCH OFFICIAL		SIGNATURE OF MINISTER		SIGNATURE OF RABBI	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		PLACE		CAUSE		MANNER		DISEASE		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
JAN 15 1920		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		NONE		NONE		NONE	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05788

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>	
c. LENGTH OF STAY in 1b <u>8 weeks</u>		d. STREET ADDRESS <u>RD 1, Box 131</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Douglas Walter</u>		4. DATE OF DEATH <u>May 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1958</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>27</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Howard Walter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reynolds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>** ** *</u>	
17. INFORMANT <u>Howard Walter</u>		Address <u>Rt. 1, Box 131</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Defect</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>5-13-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/16/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '58</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Couch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



Infant

Howard Walter

Katy Rejoign

Box 131
Rt. 1, Box 131
Save de Grace, Mo.

Serial 5/16/98 - Bel in Memorial Garden, Bel Air, Maryland

Overseen, No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG229 5-19-58 et

5787

CERTIFICATE OF DEATH

Reg. Dist. No. 05789

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harware No Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harware No Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own home</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>E E</u> Last <u>Kilpinson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13, 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harware No Grace</u>	
11. BIRTHPLACE State or foreign country <u>Harware No Grace, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip F. McGiloney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-3100</u>	
17. INFORMANT <u>Mrs. Marie Furcotte</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLISM</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Harware No Grace</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a. m.</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Dec. 1957</u> , to <u>May 5, 1958</u> , that I last saw the deceased alive on <u>May 5, 1958</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D. <u>200 N. Union Ave. - Harware No Grace, Md</u>		DATE SIGNED <u>May 12, 1958</u>	
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>May 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harlington Cn</u>	
22d. LOCATION (City, town, or county) <u>Harford Co</u>		22e. (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Bailey</u>		24. REC'D BY REGISTRAR <u>May 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alberich</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5788

CERTIFICATE OF DEATH

Reg. Dist. No. 05790

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Bradley</u> Last <u>Wimbrow</u>		4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 23, 1925</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House - wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13. BIRTHPLACE (State or foreign country) <u>Delaware</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>David Bradley</u>		16. MOTHER'S MAIDEN NAME <u>Edna Mae</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
19. INFORMANT <u>Lawrence Wimbrow</u>		Address <u>125010 Post Rd. ABER. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, metastatic</u> DUE TO (b) <u>Adenocarcinoma of the right breast</u> DUE TO (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aplastic anemia - secondary</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 11th</u> , 19 <u>58</u> , to <u>May 17th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 17th</u> , 19 <u>58</u> , and that death occurred at <u>2:58 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harre-de-Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>5/17/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GRACE LAWN, CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWCASTLE, CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 20 '58</u>	
ADDRESS <u>Harre-de-Grace, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Smith</u>	

CERTIFICATE OF DEATH

3288

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "10/25/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "C. D. Brown"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF NEXT OF KIN [Faint text, possibly "Jane Doe"]		SIGNATURE OF BURIAL OFFICIAL [Faint text, possibly "E. F. Green"]		SIGNATURE OF CHURCH OFFICIAL [Faint text, possibly "G. H. White"]		SIGNATURE OF MINISTER [Faint text, possibly "I. J. Black"]	
SIGNATURE OF CLERGYMAN [Faint text, possibly "K. L. Gray"]		SIGNATURE OF MINISTER [Faint text, possibly "M. N. Hall"]		SIGNATURE OF CHURCH OFFICIAL [Faint text, possibly "O. P. King"]		SIGNATURE OF BURIAL OFFICIAL [Faint text, possibly "Q. R. Lee"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the registrar, or by the burial official, or by the church official, or by the minister, or by the clergyman, or by the next of kin, or by the person who has taken charge of the funeral. It is to be filled out as soon as possible after the death, and before the body is buried or cremated. It is to be filled out in duplicate, and one copy is to be retained by the person who has filled it out, and the other copy is to be sent to the State Department of Health, Baltimore, Maryland.